

Instruction Sheet

Thank you for your interest in the Engineers Canada Life Insurance Product. Please follow the instructions below to apply.

Steps:

1. Please print the form.
2. Where indicated, please complete the application by providing information. Please ensure that all answers provided are complete, relevant, and accurate. If you find your answers exceed the space allotted on the form, please feel free to attach a signed/dated loose-leaf sheet of paper.
3. Sign and date the form where indicated, and provide the location where the document was signed (signed at).
4. Return the completed application to Garrett Agencies Ltd. You may do so one of three ways:
 - a. Scan & email the completed application to customerservice@garrett.ca
 - b. Fax the completed application (Toll Free) to 1-800-661-5540, or
 - c. Mail the completed application to:

Garrett Agencies Ltd.
1107 – 1122 4th Street S.W.
Calgary, Alberta
T2R 1M1

5. Once received one of our advisors will contact you to confirm receipt and to go over the details of your application to ensure its accuracy that your needs are properly met.

Should you have any questions or concerns, or would like assistance in completing this application for insurance, please feel free to contact our office and we will be more than happy to assist you.

You may reach our office toll free at 1-800-661-3300, or email us at customerservice@garrett.ca



Engineers Canada is the business name
of the Canadian Council of Professional Engineers



GARRETTAGENCIES

 **Manulife Financial**

| For your future™

1. MEMBER INFORMATION

Name of Member (PLEASE PRINT)

 Last _____ First _____ Male Female

Unit/Apt. # _____ No./Street _____ City _____ Province _____ Postal Code _____

E-mail _____ Tel. Res: (_____) _____ Bus: (_____) _____

 Member's Date of Birth (DD/MM/YY) _____ Birthplace: Country _____ Non-smoker* Smoker

 Applicant is a/an: Engineer Engineering Student Technician/Technologist Limited Licensee
 Geologist/Geoscientist Architect Permanent full-time employee of Association Member in Training
 Provisional Licensee Name of Prov./Terr. Assoc. _____ Membership No. _____

2. SPOUSE INFORMATION (If applying for spousal coverage)

Name of Spouse (PLEASE PRINT)

 Last _____ First _____ Male Female

 Spouse's Date of Birth (DD/MM/YY) _____ Birthplace: Country _____ Non-smoker* Smoker

Spouse's Occupation (If self-employed, please describe nature of business and duties) _____ Tel. Bus: (_____) _____

*Non smoker rates apply to people who have not smoked cigarettes in the last 12 months and who meet Manulife Financial's health standards.

3. I AM APPLYING FOR New coverage Additional coverage If currently insured under this Plan, your Certificate no. _____

Term Life Insurance (Do not include coverage already in force.)

MEMBER Please indicate amount you're applying for in increments of \$25,000:
 Add Insurance Continuation Benefit Yes No Coverage Amount

SPOUSE Please indicate amount you're applying for in increments of \$25,000:
 Add Insurance Continuation Benefit Yes No Coverage Amount

Major Accident Protection (Please indicate the amount you are applying for)

Member:					
Major Impairment	[Up to \$100,000	[Up to \$200,000	[Up to \$300,000	[Up to \$400,000	[Up to \$500,000
Accidental Death	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Your Monthly Premium	\$1.50 <input type="checkbox"/>	\$3.00 <input type="checkbox"/>	\$4.50 <input type="checkbox"/>	\$6.00 <input type="checkbox"/>	\$7.50 <input type="checkbox"/>
Spouse:					
Major Impairment	[Up to \$100,000	[Up to \$200,000	[Up to \$300,000	[Up to \$400,000	[Up to \$500,000
Accidental Death	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Your Monthly Premium	\$1.50 <input type="checkbox"/>	\$3.00 <input type="checkbox"/>	\$4.50 <input type="checkbox"/>	\$6.00 <input type="checkbox"/>	\$7.50 <input type="checkbox"/>

Child Life and Accident Insurance (The monthly premium covers all of your eligible children.)

Major Impairment	[Up to \$50,000	[Up to \$100,000	[Up to \$150,000	[Up to \$200,000
Term Life	\$5,000	\$10,000	\$15,000	\$20,000
Monthly Premium	\$1.17 <input type="checkbox"/>	\$2.34 <input type="checkbox"/>	\$3.51 <input type="checkbox"/>	\$4.68 <input type="checkbox"/>

4. BENEFICIARY INFORMATION

Beneficiary on Member's Coverage

Last name _____ First name _____

Relationship _____

Beneficiary on Spousal Coverage

Last name _____ First name _____

Relationship _____

 In Québec, a spouse designated on this application as beneficiary is irrevocable unless otherwise stated. I hereby appoint my spouse as a revocable beneficiary.

5. HEALTH DECLARATION

Member's Physician – Name:	Tel. # ()	Date last seen: (DD/MM/YYYY)
Reason:	Result:	
Spouse's Physician – Name:	Tel. # ()	Date last seen: (DD/MM/YYYY)
Reason:	Result:	
Member's Height: <input type="checkbox"/> ft/in <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kgs	Spouse's Height: <input type="checkbox"/> ft/in <input type="checkbox"/> cm
		Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kgs

Has any individual proposed for coverage (member, spouse, children):

1. Ever applied for any insurance that was declined, modified or rated?
If yes, give details including name of applicant, date, name of company and reason: _____
2. Within the past 5 years, had your driver's license suspended or been charged with impaired driving or had more than 3 driving violations? If yes, give details including name of applicant, nature of offence(s), date(s), Driver's License # and Licensing province: _____
3. Have any intention of piloting an aircraft or participating in scuba diving, parachuting, hang gliding, motor vehicle racing, climbing or any other hazardous activity? If yes, give details including name of applicant, type of activity and date(s): _____
4. Within the next 12 months, have you any intention of traveling or residing outside North America?
If "yes", give details including name of applicant, where, when, why and for how long. _____
5. Within the past 7 years, used drugs for other than medical purposes, used marijuana or been treated for or advised to reduce alcohol or drug use? If yes, give details including name of applicant, drug or alcohol type(s) and date(s) last used: _____
6. Ever had any indication of or been treated for a mental or nervous disorder (depression, anxiety, stress etc.), disorder of the brain or nervous system, heart or blood vessels, chest pains, heart murmur, high blood pressure, elevated cholesterol, diabetes, cancer, tumour, lung or liver disorder, hepatitis (including hepatitis carrier state), kidney disorder, urinary abnormality, prostate disorder, blood disorder, lymph or glandular disorder, unusual infection, breast disorder, thyroid disorder, skin disorder, gastrointestinal disorder or other illness not mentioned?
7. Ever had any joint or musculoskeletal problems (back, neck, hip, knees, etc), arthritis, paralysis or weakness, fibromyalgia or chronic pain, had x-rays of spine or joints or been hospitalized or been medically disabled for more than two consecutive weeks?
8. Ever had any positive test, treatment for or exposure to HIV virus or AIDS?
9. Within the past 2 years, had an abnormal mammogram, PSA or any other test or investigation, consulted a specialist, been prescribed medication, other treatment or counseling for any disorder other than minor ailments (colds, flu etc), been advised to undergo further investigation, see another doctor or have surgery?

Member		Spouse		Child(ren)	
YES	NO	YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please complete only if applying for Child Life and Accident

Name of Child	Gender	Date of Birth	Height	Weight	Name and Address of Family Doctor
	<input type="checkbox"/> M <input type="checkbox"/> F	DD / MM / YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD / MM / YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD / MM / YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	
	<input type="checkbox"/> M <input type="checkbox"/> F	DD / MM / YYYY	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	<input type="checkbox"/> lbs <input type="checkbox"/> kgs	

If applying for more than four children, please complete a separate signed and dated page.

Please ensure all questions are answered and details provided for all individuals applying for coverage (member, spouse and children).
If you require additional space, please use a separate page, signed and dated.

For more information about these and other Engineers Canada-sponsored P
For personal service, call us toll-free at **1 877 598-2273**, Monday through Friday

5. HEALTH DECLARATION (continued)

10. Other Insurance

Do you (Applicant or Spouse) have any pending or existing life insurance coverage with Manulife Financial or any other company?

Yes No If yes, complete the following:

Name of Applicant	Company Name	Personal or Business	Coverage Amount	Do you intend to replace this coverage?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: If you intend to replace coverage, do not cancel your existing coverage until you receive and review your new life contract

11. Financial Information (Complete only if total coverage (applied and existing) exceeds \$250,000)

Member Annual Net Income, after expenses but before tax \$ _____	Spouse Annual Net Income, after expenses but before tax \$ _____
Personal Net Worth (assets less liabilities) \$ _____	Personal Net Worth (assets less liabilities) \$ _____

If you answered "yes" to Questions 7 through 9, please give details below. If additional space is needed, use a separate sheet, signed and dated.

Question #	Name
Nature of Disorder	
Duration & Date	
Result	
Attending Physician or Hospital	

Question #	Name
Nature of Disorder	
Duration & Date	
Result	
Attending Physician or Hospital	

Question #	Name
Nature of Disorder	
Duration & Date	
Result	
Attending Physician or Hospital	

Note: The insurer may request a medical examination, urinalysis or tests such as general blood profile (including blood test for HIV) which will be made at no expense to the applicant. Results of any positive infectious disease tests will be reported to the appropriate provincial or territorial health department if required by law. Please note that, based on your health information, Manulife Financial may offer insurance on an alternative basis or may decline to offer coverage.

Plans or to apply, visit www.manulife.com/EngineersCanadaTL today.

or call from 8 a.m. to 8 p.m. ET, or e-mail us  am_service@manulife.com any time.

CON'T. >

